UNIVERSITY OF CALIFORNIA RIVERSIDE
RADIATION WORKER LOST BADGE NOTICE REPORT

Name: Last_____ First_____ Middle_____

Employee/ Student ID #: _____

Date of Birth: _____

Primary Investigator _____

Department: _____

Location (Building/ Room): _____

Approximate Date of Loss: _____

Badge Type (circle): Whole Body Ring/ Extremity Fetal

Wear Period: Start _____ End _____

Replacement Requested: Yes No

I estimate the dose received during the lost wear period was
___ less than ___ equal to ___ greater than the normal dose exposures I would normally receive.

Signature _____ Date _____

Office Use:
Part# __ __ __ __ __ **Series Code** __ __ __ __ __ __ __ __